Anschutz Health and Wellness Center
UNIVERSITY OF COLORADO
ANSCHUTZ MEDICAL CAMPUS

PATIENT DEMOGRAPHICS

# PATIENT HEALTH INSURANCE WAIVER

I have requested services and/or therapies provided by a medical provider of the University of Colorado Denver School of Medicine. I understand that these services and/or therapies will be billed by University Physicians, Inc. I further understand I may be responsible for all charges incurred today for (service/cpt code) _____ by (provider)_____ ***even if I elect to have my insurance billed first.***

Estimate of UPI charges_____ (**this is only an estimate and may not be the full financial responsibility).**

❒ The **provider** performing the above services or therapies is **not a participating provider** with my health insurance. Therefore these services/therapies are not covered by my policy.
_____Bill insurance ____Do not bill insurance (Elective Self Pay)

❒ The **scope of services** rendered by this **provider** may not be covered by my health insurance policy.
_____Bill insurance ____Do not bill insurance (Elective Self Pay)

❒ The appropriate **authorization** required by my health insurance policy **has not been obtained** from my primary care physician. It is my personal decision not to obtain the authorization from my primary care physician.
_____Bill insurance ____Do not bill insurance (Elective Self Pay)

❒ No claim will be sent to my insurance since it is my personal **decision not to use my health insurance** benefits for the above service/therapy even though I understand that these services/therapies are considered covered by my policy. (Elective Self Pay)

**Patient Signature** (or parent/guardian/other-authorized person if patient is a minor, mentally incompetent, or physically unable to sign this form)

_____ **Date** _____
**Printed Name and Relationship of Person Authorized to Sign for Patient**

_____
**Reason Patient is Unable to Sign**

**Insurance Waiver Explained by:** _____
**(Printed Name of Hospital or UPI Representative)**

_____ _____
**Signature of Hospital or UPI Representative** **Date**

University Physicians, Inc.